COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH
INDIVIDUALIZED SERVICE DELIVERY SUPERVISION PLAN

I. IDENTIFYING INFORMATION

Employee Name: _____
First Last

Unit: _____

Discipline: _____ Ph.D. _____ M.S.W. _____ M.D. _____ R.N.

Other: _____

Licensed: _____ Yes _____ No

Staff Category:
_____ Probationer until _____
_____ New Employee for 3 months ending _____
_____ Medi-Cal Reimbursable, Licensable or Registered
_____ Waivered Psychologist or Social Worker
_____ Adjunctive Therapist
_____ Unlicensed
_____ Student, Intern, Trainee
_____ Volunteer

Employee Status: _____ Full-Time _____ Part-Time (Specify)

II. FORMAL SUPERVISION/CONSULTATION

Type	Frequency	Conducted by	Title	Date(s) of Actual Supervision
_____Individual Performance Centered Supervision/ Consultation	_____	_____	_____	_____
_____Case Staffing	_____	_____	_____	_____

Type	Frequency	Conducted by	Title	Date(s) of Actual Supervision
_____ Special Clinical Problems Presentation/ Conference	_____	_____	_____	_____
_____ Inter-Departmental Case/Centered Conference	_____	_____	_____	_____
_____ Staff Meeting with Case Centered Focus	_____	_____	_____	_____
_____ Medical Supervision	_____	_____	_____	_____

_____ Other(Specify) _____

_____

III. OTHER TRAINING/PROFESSIONAL DEVELOPMENT ACTIVITIES

List any other training or professional development activities which are part of the plan.

a. _____

_____

b. _____

_____

c. _____

_____

I have developed this plan with the supervisor and agree.

_____ _____
Supervisee Date

I have developed this plan with the supervisee and agree to ensure that it is adhered to.

_____ _____
Supervisor Date

I approve the above plan.

_____ _____
Unit Administrator Date

c: Unit Administrator
Office File
Employee